

FILED AUG 2-1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24549

State File No.

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 5402	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3003 a Iowa Ave				STREET ADDRESS (If rural, give location) 224 3003a Iowa Ave			
3. NAME OF DECEASED (Type or Print) Elizabeth		a. (First)		b. (Middle) L.		c. (Last) Werner	
4. DATE OF DEATH June 21 1955		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	
8. DATE OF BIRTH Nov 18 1879		9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bag Sewer		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Anthony Werner		13b. MOTHER'S MAIDEN NAME Elizabeth Rose		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 493-07-5911		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Josephine Higgins 3003a Iowa			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. HOW DID INJURY OCCUR? 331X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from 6-1 , 19 55 , to 6-21 , 19 55 , that I last saw the deceased alive on 6-21 , 19 55 , and that death occurred at 1 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE Joseph E. Carney MD		23b. ADDRESS 906 Olive St		23c. DATE SIGNED 6-22-55			
24a. BURIAL CREMATION REMOVAL (Specify) Burial		24b. DATE June 24 1955		24c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemety		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. JUN 22 1955		REGISTRAR'S SIGNATURE Charles Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Weick Bros 2201 S. Grand Blvd			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Ronald O. Yalub

Licensed Embalmer No. *391*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.